State Opportunities under the American Recovery and Reinvestment Act:

Health Information Technology (Title XIII)

In addition to providing flexible appropriations and formula funds to states and individuals for stimulus purposes, the American Recovery and Reinvestment Act also provides resources to states to create long-run economic growth opportunities. The four key areas are: (1) health information technology, (2) energy and green jobs programs, (3) broadband infrastructure and deployment, and (4) research and development. This paper describes the opportunities available to states to establish a health information network for electronic health records. The other three papers may be found at www.nga.org/ARRA .

Summary

The American Recovery and Reinvestment Act includes several key provisions designed to create a national health information network for the exchange of electronic health records. The key provisions of interest to states are:

1. a grant program for states (or state-designated entities) to plan for and help build a health records exchange,
2. a loan program, to be administered by states, to help providers purchase the equipment they need to "plug into" the exchange, and
3. a financial assistance program (to be administered by states under Medicaid) to Medicaid providers who purchase and use HIT equipment, with no matching funds required.

The bill places a great deal of responsibility on the states to plan and help create a nationwide electronic health records (EHR) exchange. Each governor will need to designate the entity (public or private) that will lead the development of the exchange within their state. These entities can apply for two types of competitive grants as soon as guidance is released by HHS—a planning grant and an implementation grant. Only states that have detailed plans in place may apply for an implementation grant. Grant guidance is expected to be released after HHS completes a strategic plan for HIT adoption, due 90 days after ARRA enactment.

States receiving HIT grants will need to move quickly to create a business and oversight plan for the exchange—which includes choosing how patient records will be transmitted, stored, and protected; helping determine how the exchange will be financed and sustained; and identifying the process for managing Medicaid reimbursements to doctors for installing and using EHR equipment.

1 State Grants to Promote Health IT (Sec. 3013)

1.1 Purpose

- This section would provide competitive grants to "States or qualified State-designated entity" for two separate types of activities: (1) planning and (2) implementation "for the support of the physical and organizational infrastructure for health information exchange

statewide." Requirements for both grant programs would be established by the Office of the National Coordinator (ONC) in HHS.

1.2 Funding Level

- The potential amount for these grants is unstated, but the monies are to be drawn from the $2 billion appropriated to ONC for these and other purposes. These dollars are allocated to ONC to use for both state planning and implementation grants and the loan program (described below). In addition, some of the monies are allocated to other federal efforts and programs (totaling about $100 million). The law also states that at least $300 million is to be allocated to "regional and subnational efforts", which presumably includes states.

1.3 2008 Appropriations

- No previous appropriations. This is a new program.

1.4 Mechanism and Use of Funds

- These are competitive grants to be awarded to "States or qualified State-designated entity". There is little specificity, but the activities that could be addressed in both planning and implementation grants include enhancing participation in statewide and nationwide exchange of information, providing technical assistance for the development of exchanges, addressing the needs of safety net providers, promoting the use of EHRs for quality and public health purposes, and educating consumers. In addition, states applying for implementation grants likely will need to demonstrate that they have created a governance structure, chosen the technical parameters and requirements for the exchange, and have developed a sustainable business model for operating the exchange. The law does not specify whether grant funds may be used for the purchase of equipment or other infrastructure to create the exchange, but the broad language would appear to support such uses.

- Funds are available for 5 years (FFY 2009-2013) or until expended. States must meet a match requirement, but not until 2011 and at a increasing rate thereafter. (State match cannot be less than: 2011-10%; 2012-14%; and 2013-33%).

1.5 Issues for Governors

- Some states may already have made considerable progress in preparing for the establishment of a health information exchange network. However, it is likely that even advanced states will need to revise their plans to harmonize their implementation strategy with the new grant guidance. For other states, considerable work will need to be done quickly to create a plan for implementation.

- Since ONC must first revise its overall strategy within 90 days, grant guidance (for planning grants) should not be available before that time. While many states will need 6 to 12 months of planning with their stakeholders, some states may be in a position to move quickly toward implementation. However, the time needed for HHS to certify equipment and set standards may delay the release of implementation grants.

- It is not clear how much, if any, grant funding will be available to build central elements of the exchange, which may include large servers to house the data sent in by labs and providers.

- A key early decision will be the governance structure for the exchange. Some states may choose to manage the exchange directly, perhaps housing it under a state agency. Other states—perhaps the majority—may assign it to a state designated entity, such as a university or non-profit public-private partnership. In either case, it is likely that states will need to play a major role in (1) protecting privacy and ensuring records are used according to state and HIPPA regulation and (2) establishing a sustainable business model for the exchange, including setting and allocating charges among exchange participants.

2 Competitive Grants to States and Indian Tribes for the Development of Loan Programs to Facilitate the Widespread Adoption of Certified EHR Technology (Sec. 3014)

2.1 Purpose

- Provide grants to states and tribes to support loans to any eligible health care provider to cover the costs of purchasing an EHR. The grantees must develop a loan fund from which to make and guarantee loans. The law stipulates that the loan program may begin no sooner that January 1, 2010. In fact, until HHS certifies technology for purchase, the loan program will have no practical application.

2.2 Funding Level

- The potential amount for these grants is unstated. Funding for this program must be shared with the other state grant programs using the $2 billion allocated to ONC (discussed earlier).

2.3 2008 Appropriations

- No previous appropriations. This is a new program.

2.4 Mechanism and Use of Funds

- States must apply for a competitive grant to administer the loan program.

- Loan funds can be used by health care providers to purchase certified EHR technology, improve EHR utility (presumably for existing EHR systems), train personnel, and improve secure exchange of health information. The state must have in place requirements and accountability mechanisms to ensure that fund dollars are only used for the purchase of certified products. Providers must agree to submit reports on quality measures determined by the federal government in order to be eligible for loan funds. The Fund can accept contributions from the private sector to be used in the same fashion as federal funds. Interest accrued on these private dollars should also be rededicated into the Fund.

- Interest rates must be market based, and interest payments return to the Loan Fund. The Fund can use only 4% for administrative and oversight costs. States must match contributions to the Loan Fund by providing $1 for every $5 in federal funds, but private

sector contributions to the Fund can be deemed as contributing to this match requirement. This grant program does not begin until Jan 1, 2010.

2.5 Issues for Governors

- A loan program will not be practical until a federal certification program is up and running and an exchange is in place. However, states will need to apply for this loan fund program at the same time they begin establishing an exchange, since it will be a crucial component for getting EHR equipment into provider's hands

3 Medicaid-based reimbursement for EHR technology

- The package authorizes payments to qualified health care providers under Medicare and Medicaid for the purchase and use of EHRs. States will manage the Medicaid reimbursements to providers. No match will be required for these payments but states will incur additional administrative costs and must ensure that providers demonstrate "meaningful use' of EHRs. The Act stipulates that 90 percent of state administrative costs will be covered. Both the Medicare and Medicaid incentive payments will not be available to providers until 2011.

3.1 Purpose

- The incentives are designed to motivate and support the purchase and use of EHRs by Medicaid and Medicare providers.

3.2 Funding Level

- CBO estimates that the payment incentives would increase spending for the Medicare and Medicaid programs by $32 billion over the 2009-2019 period.

3.3 2008 Appropriations

- This is a new program and an entitlement.

3.4 Mechanism and Use of Funds (Medicaid)

- Eligible providers would receive reimbursement for the purchase and implementation of EHRs. Eligible providers include non-hospital providers; Federally Qualified Health Centers (FQHC), rural health clinics with at least 30% Medicaid (acute), and children's hospitals with at least 10% Medicaid. Other hospitals would fall under the Medicare incentive program.

- Providers also are eligible for reimbursement for ongoing maintenance costs for 5 years. Although there are slight variations, generally the proposal allows for eligible non-hospital providers to receive up to 85% of their costs for purchasing and implementing certified technology (maximum $25,000 per office-based practitioner for 5 years, and $10,000 thereafter for maintenance, with an aggregate cap of $75,000 over 5 years; FQHCs would receive at least 85% of their costs and would have a maximum cap of $75,000 across the 5 years that will be established by the HHS Secretary).

- There is no state match required, and states may use 10% for administration and oversight, particularly to ensure the purchase and use of certified technology.

3.5 Issues for Governors

- States must develop a mechanism for ensuring the technology is used by practitioners. One requirement calls for the state to secure "routine attestation" from providers that the technology is being meaningfully used. States also may be required to periodically audit providers to ensure providers are accessing EHRs. It is assumed that ONC will provide guidance to states on options for administering the incentives and ensuring meaningful use of EHRs by providers.

- States also will have to ensure that only certified technology is purchased. Again, certification is still young in this area, and there may be challenges in having a sufficient amount of choices available to providers. Finally, similar reimbursement policies will also be available to Medicare providers. There is a stipulation charging HHS with addressing "non-duplication" between Medicaid and Medicare, and states will need to work with HHS to avoid double billing.